

Minnesota Aging Pathways Volunteer Hours / Expense Report

Name:	Quarterly Reporting Months:
Address:	Please submit this report by the last Wednesday of each quarter to:
City, State, Zip:	Volunteer Coordinator, Central MN Council on Aging, 3333 W Division St, Ste 217, St. Cloud, MN 56301

Date	Type of Activity/Event	Hours *	Location	Miles **	Other Allowable Expenses	Total
Total Hours:		Total Miles:		Mileage:		
* .5 increments ** Round to nearest mile					Total Reimbursement:	

For CMCOA Office use only:

Element Code: _____

GL Code Volunteer Mileage 52400: _____

GL Code Postage 53400: _____

GL Code: _____

I declare under penalty of law that this claim is just and correct and that no part of it has been paid or otherwise reimbursed according to IRS Regulations.

_____ Date: _____

(Volunteer signature)

(Coordinator signature)

Please Note: Our auditor requires that we have receipts for all expenses. Please remember to attach all receipts to receive reimbursement. Thank you.